Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BRUCE WHITEHEAD, MD
PO BOX 741865
DALLAS, TEXAS 75374

Respondent Name

HARTFORD INS CO OF THE MIDWEST

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-1390-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DD EXAMS" and "REQUIRED TESTING REQUESTED BY THE DD"

Amount in Dispute: $572.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CLAIM IS NON-COMPENSABLE" and "Per peer review on 8/17/10-no further treatment reasonable or necessary"

Response Submitted by: Specialty Risk Services, 1851 East 1st #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 2010	99456-RE-W6 and 95851	$572.06	$572.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203 sets out Medical Fee Guidelines for Professional Services.

4. Texas Labor Code Title 5, Subtitle A, Chapter Subchapter A, in §408.0041(a-h) provides general provisions for Designated Doctor (DD) Examinations and carrier responsibilities for payment of such services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 12, 2010
   - 214 – Workers Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Services denied. Please contact the Claims Examiner regarding these charges.

   Explanation of benefits dated December 13, 2010
   - 18 – Duplicate claim/service.
   - 214 – Workers Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Services denied. Please contact the Claims Examiner regarding these charges.

   Explanation of benefits post MFDR dated January 26, 2011
   - Services denied. Please contact the Claims Examiner regarding these charges.

Issues

1. Has the Designated Doctor (DD) Examination been reimbursed appropriately per 28 Texas Administrative Code §134.203 and §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.203 and §134.204?

Findings

1. The Respondent denied reimbursement with "18 - Duplicate claim/service." The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported. Also, Respondent denied services with "214 – Workers Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Services denied. Please contact the Claims Examiner regarding these charges." The Plain Language Notice (PLN-11) on file is dated October 28, 2010 (after date of service) and states:

   > "Carrier accepts a compensable injury in the form of a lumbar strain/strain only hip strain and knee strain. No other injuries, diagnoses, symptoms or conditions are accepted. Carrier disputes any injury other than a lumbar strain/strain, hip strain and knee strain as not compensable and not sustained in the course and scope of employment. Carrier denies the injury extends to or includes lumbar disc herniations or neuritis."

   Review of the CMS-1500 and documentation shows the ICD-9 code 847.2 for Lumbar Strain. Therefore the denial reason is unsupported; this claim is compensable.

   Regardless of any PLN-11 content, DWC may order an examination and require its payment according to the Texas Labor Code §408.0041 which states in part (a)(3):

   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:

   (3) the extent of the employee's compensable injury;

   Texas Labor Code §408.0041 states in (h)(1):

   (h) The insurance carrier shall pay for:

   (1) an examination required under Subsection (a) or (f).

   Review of the documentation supports DWC ordered services were performed. The respondent uses the position statement, "Per peer review on 8/17/10-no further treatment reasonable or necessary.**"** A peer review has no bearing on reimbursement of a DWC ordered examination which is not treatment. The reimbursement is according to the Medical Fee Guideline.
2. 28 Texas Administrative Code §134.204(k) which states:

   > "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

Requestor billed CPT code 99456-RE-W6 for Extent of Injury (EXT) as well as CPT code 95851 for Range of Motion (ROM) testing. Review of the documentation supports 3 units of ROM testing performed to the compensable injury. The MAR calculation for the ROM testing is reimbursed according to 28 Texas Administrative Code §134.203(c). The service location of Bedford, TX in zip code 76021 (Tarrant County) has a MAR of $24.69 x 3 units = $74.07. The combined MAR of EXT examination and the ROM testing is $574.07. As the disputed amount is $572.06, this lesser amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $572.06.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $572.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 18, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.